THE RELATION OF THE VISITING AND HOUSE STAFF TO THE CARE OF HOSPITAL PATIENTS.

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By W. GILMAN THOMPSON, M. D.,
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The Visiting Staff.—Many of us listened recently to the able Anniversary Discourse of the Academy of Medicine, by Dr. Gerster. One of the suggestions therein urged was that hospitals should employ paid medical officers, thereby commanding more of their time, and promoting economy of administration. This proposition leads to the question whether continuous service on the part of the visiting staff does or does not especially benefit the patient, and it is this phase of the matter only which may be properly considered in the subdivision of topics which has been assigned to me.

Classified upon the service basis, there are at present in this country three distinct groups of public hospitals. First, those to which any reputable physician may send patients, and personally treat them there for any period he may choose. Examples of this system are found in Denver and several other cities. Second, hospitals in which a comparatively small paid permanent visiting staff enjoys an absolute monopoly, a system illustrated in Baltimore and a few other cities. Third, hospitals managed upon an intermediate system, with a large visiting staff and reasonable rotation of service, which is at present the prevailing type.

It has never been clearly demonstrated that the

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results of treatment in any one of these three groups of hospitals were markedly and continuously better than in the others. It is the men employed, rather than the system, which in any specific case make for success or failure. It might be possible to allot a permanent service to one who soon reached his limitations of development and kept both house staff, nurses, and patients within the confines of his own narrow mindedness. Arbitrary age limitations may be set upon the service, but we have all known men whose work we would applaud long after sixty-five years of age, and those who reached their limit of usefulness at thirty.

The day of preeminence in medical *treatment* (not of course in medical scientific *discovery*) belongs to past generations, for, on the one hand, the general average of medical education and training is being elevated year by year, and upon the other, the field of knowledge is becoming far too broad to permit of monopoly. To whom would one look to-day as preeminent in the treatment of pneumonia, of cirrhosis, of endocarditis? It is not a hospital question of Doctor So and So's prescriptions or individual methods with his patients, but rather of nursing and dieting and hygiene, with the skillful use of a few medicinal remedies common for all practitioners.

The question of continuous hospital service—that is, of appointing one or two visitants with assistants to serve the year round (whether paid or not)—is somewhat different as viewed from the surgical or medical standpoint. The surgeon needs to train his house staff and nurses in his individual methods of antisepsis and operation; he handles a large number of implements, in the use of which also his staff must be trained, and cases of laparotomy, of fracture, of amputation, may prove slow in recovery, and should be watched to their conclusion by the operator. To make frequent change in such service is to transfer to one's successor a number of cases of the

real nature of which he necessarily can know but little. In a medical service, on the other hand, occasional change of visiting physicians may prove an advantage. There is a decided gain to the interne in coming in close contact with more than one instructor, who widens thereby his experience, and there may be decided gain to the patient in the occasional introduction of new methods, the avoidance of too much routine, or the revision of obscure diagnosis. In the so called active service of one of the largest metropolitan hospitals the average per capita stay of the medical patients is only eleven days, and an occasional change of visiting physician is found to have no practical disadvantages whatever. One might go further and say that it is a distinct gain to the hospital sometimes to appoint a visiting physician whose experience is in part gathered at a sister institution where he also visits, and from which he may introduce from time to time new suggestions both for the benefit of the patients and economy of the institution. Moreover, the best hospital visitant may derive profit from the experience or opinions of those who precede or follow his own service.

But to argue this question solely from the standpoint of the hospital patients in any one institution is to present a narrow field of view. Hospital patients constitute a very small proportion of the total sick in any community. The humanitarian influence of any hospital would be sadly restricted were it possible to confine it to the few thousand patients treated within its walls. It is essentially a great educational factor, educating its nurses, its internes, its special students, and its visiting staff to serve the community at large. In just so far as it can increase the number of all these classes of workers within reasonable limits, and without unfavorable reaction upon its patients, its influence for good will extend. The hospital which places three or four hundred

medical patients under the charge of a single man who devotes his entire time to its service (perhaps with one or two assistants), therefore deliberately restricts its sphere of usefulness without adequate gain to the patients.

It is interesting to note what the effect would be were all the hospitals in New York city established upon such a continuous medical service basis. In the borough of Manhattan alone are twenty-eight hospitals, for the treatment of general diseases, large enough to at present employ more than one physician each. Leaving out of count all assistant or junior members of the visiting staff, and speaking only of the medical service, and not including the surgical staff, these hospitals at present employ 156 visiting physicians. In one or two instances the subdivision of service thus entailed may be excessive, and the rotation too frequent for the benefit of the patients and for the economic interests of the institution, but, on the other hand, it is a grave question whether the broadest public interest would be better served by placing the entire medical general hospital service in a city of the size of New York in the hands of a monopoly of twenty-eight men.

The question of hospital economics belongs to the paid superintendent's office, and should be met by securing greater efficiency, if need be, in that department. Proper cooperation of the visiting staff in maintaining economy is most essential, but the time and energy of the visitant belong to his patients and the development of his science, and should not be frittered away with purely administrative details, with such questions, for example, as whether it is cheaper to sterilize old gauze and use it again, or use green medicine bottles instead of white!

The Internes.—There are two factors of recent development which seriously tend to interfere with that close study and watchful care which the members of the house staff owe to the patients in their

charge. One of these is the clinical laboratory, the other the overtrained nurse.

The growth of so called "clinical laboratory" methods is phenomenal. They afford interesting and for the most part valuable aids to diagnosis, and being visible and tangible methods they naturally impress the mind of the beginner in medicine as opening a royal road to diagnosis—diagnosis "while you wait"—in the laboratory! Why give quinine if a single examination fails to reveal the plasmodium malariæ, and why give it at all until the patient has had several chills, thus allowing time to discover the plasmodium? Why open the window and let in fresh air to the obviously tuberculous patient because the first examination has failed to demonstrate the presence of the tubercle bacillus? Why begin the treatment of chlorosis or lead poisoning until the exact proportion of polymorphonuclear nutrophiles or granular basophiles has been definitely established?

Far be it from the intent of this criticism to disparage the value of laboratory methods—*i. e.*, the use of physical and chemical tests for diagnosis. On the positive side they are often of great interest and practical importance, and may be of unique service (as when the accidental discovery of an eosinophilia in a routine blood count leads to the demonstration of an intestinal parasite). On the negative side, however, they may be actually harmful, if too much weight is given to such evidence, as when repeated failure to obtain a positive Widal reaction is made to outweigh bedside evidence of typhoid fever. In just so far as they lead the house staff away from bedside methods of close observation they work injustice to the patient.

I have known of a house physician who was so eager to search for leucocytosis in a case of pneumonia that he was unable to tell upon which side of the patient's chest the lesion was present. Surely

it is possible to spend so much time in the laboratory in a microscopical quest for the ticks on the lost sheep, that the ninety and nine may die meanwhile of pleuropneumonia in the wards above.

To offset this increasing difficulty in the relationship of interne to patient, some hospitals have devised a system of pathological externeships—*i. e.*, of entering young men upon the staff, who serve in part as assistants in the strictly pathological work of the hospital, and in part relieve the house staff of clinical laboratory work in uranalysis, blood and sputum examinations, etc. This system, when carefully supervised, has certain advantages, and admits of more extensive research work, but if not so supervised, it reacts in turn upon both patient and house staff. For example, it was a recent personal experience to find a single patient, having a probable tuberculous enteritis, whose blood, secreta and excreta had been examined in the brief period of seven weeks by no less than twelve different appointees of the pathological department of the hospital and members of the house staff. Upon further inquiry the fact was elicited that fully three hours daily of the junior interne's time was consumed in transcribing upon the various ward patients' history charts the results of clinical laboratory analyses—purely duplicate clerical work that could be avoided by the use of a simple copying apparatus. If that young man were required to spend those three hours daily in studying the proper diet of the patients, the heating, ventilating and lighting of their wards, and securing in manifold other ways their comfort in beds, by the time he became house physician or surgeon he would know something of these matters and develop into a much more skillful practitioner.

Twenty years ago the clinical laboratory examinations consisted of little more than a search for casts and albumin, or sugar in the urine. To-day the armamentarium of the interne comprises tonometers,

hæmoglobinometers, hæmocytometers, coagulinometers, multitudinous staining agents, chemical reagents, etc., etc., apparatus, much of which his visiting chief would be puzzled to personally handle. Some degree of familiarity with their use is doubtless desirable, but the actual data thus obtained are of little service to patients and the science of medicine unless they are of unquestioned accuracy. Many of the clinical laboratory tests, to be reliable, should be made by the trained expert, rather than the young interne, just out of college, who is often so overburdened with the routine work imposed upon him that he can neither find time to perfect himself in physical diagnosis, or to do any reading at all in connection with his cases.

The second obstacle between interne and patient is the modern training school system for nurses, which is absorbing for itself, through pedagogic ambition, a power and importance never originally contemplated by the medical profession.

The overtrained nurse is expected to learn almost as much physiology, anatomy, and bacteriology as is required in the first year of a medical student's curriculum, and to spend at least one third more time in hospital service than does the interne. Now what has this system to do with the patient? Let me take a specific illustration from fact. It was recently discovered in one of our most widely known hospitals that an interne had been graduated without ever having given personally a hypodermic injection. Shortly thereafter he was sent by a practitioner to give such an injection of morphine to a patient. The patient complained that he did not want to see that young doctor again, for "he was so clumsy and hurt him so much." In his defence the young man explained that the "nurses always did all that sort of thing, and he supposed it would make trouble if he interfered." Upon further inquiry in the hospital, it was found that the internes

almost never applied dry cups, passed rectal or stomach tubes, or did many like services for their patients, because the nurses had appropriated all such duties themselves. That the nurses should be taught to perform them is both reasonable and proper, but that they should do so to the entire exclusion of the internes is most undesirable.

It was formerly a trite saying that "a good doctor should begin by being a good nurse." Of this one now hears but little, and the patient, if not the physician, is the loser. The nurses themselves are so busy in routine work and in pursuit of the academic exercises of their elaborate curriculum, and are drilled into such mechanical methods, that the unfortunate patient must take the consequences.

What a picture of neatness and discomfort the usual large hospital ward presents to-day! The window shades are all at the same level, no matter what patient with a raging headache and photophobia is obliged to look into the sunlight; the bed clothing, lest it appear wrinkled, is pinned as taut as a board over the cramped and hyperextended feet; the bedside tables are all placed exactly on the line, no matter whether the patient is right or left handed, or happens to be paralyzed on the wrong side—for the table; there is a notable absence of comfortable headrests, footrests and easy chairs; every one in the ward is awakened at the same early hour (in one notable case at 4:30 a. m.!) so that the night nurse can turn the service over in perfect order to her successors of the day, and the long suffering patient with cardiac dyspnœa and orthopnœa, or the sensitive neurasthenic trying to catch a morning nap, must bestir himself betimes and have his face washed and hair combed. The hospital engineer has orders to keep the ward day and night at the same inflexible temperature of 70 degrees F., and the pneumonia patient, burning with fever, in sore need of fresh, pure air, lies in the next bed to the

uræmic with a subnormal temperature who needs a good sweat in a hot pack.

This picture is no exaggeration; it is all based upon observed fact; nor is it peculiar to any single one of our larger hospitals, where wards of twenty-five beds, and the consequent difficulty of classifying patients, and also necessary economy of administration, have developed it. Neatness, and order, and discipline must prevail to administer any such institution properly, but inflexible, unthinking routine should not be allowed to deprive the sick and suffering of reasonable individual comfort.

It is in all these matters that the relations of the house staff, as well as of the nurses, to the patients committed to their care are often lamentably deficient, and there is danger lest the present emphasis given to the science of diagnosis shall more and more obscure their training in the humanitarian side of their calling, and the realization that there are other methods of treatment besides the mere ordering of pills and potions.

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